STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150034	A. BUILDING _____ B. WING _____	01/17/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST MARY MEDICAL CENTER INC	1500 S LAKE PARK AVE HOBART, IN 46342

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a state licensure hospital complaint. Complaint Number: IN00094909 Unsubstantiated: lack of sufficient evidence Date: 1/17/12 Facility Number: 005786 Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor St. Mary Medical Center is in compliance with 410 IAC 15-1.6-2, Emergency services, and 410 IAC 15-1.5-5, Medical staff, Indiana Hospital Licensure Rules. QA: claughlin 01/31/12	S 000		